

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #: _____

Address: _____

Occupation: _____ Date of Birth: _____

Have you received Thai massage therapy before? YES NO

Did a health care practitioner refer you for Thai massage therapy? YES NO

If yes, please provide their name and address: _____

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u> High blood pressure Low blood pressure Chronic congestive heart failure Heart attack Phlebitis/varicose veins Stroke/CVA Pacemaker or similar device Heart disease</p> <p>Is there a family history of any of the above? YES NO</p> <p><u>Respiratory</u> Chronic cough Shortness of breath Bronchitis Asthma Emphysema</p> <p>Is there a family history of any of the above? YES NO</p>	<p><u>Head/Neck</u> History of headaches History of migraines Vision problems Vision loss Ear problems Hearing loss</p> <p><u>Other Conditions</u> Loss of sensation, where? _____ Diabetes, onset: _____ Allergies/hypersensitivity to what? _____ Type of reaction: _____ Cancer, where? _____ Skin conditions, what? _____</p> <p>Epilepsy Arthritis Is there a family history of arthritis? YES NO</p>	<p><u>Woman</u> Pregnant, due: _____ Gynecological conditions, what? _____</p> <p>Overall, how is your general health? _____</p> <p>Primary Care Physician: _____</p> <p>Address: _____</p>
<p>Current Medications: _____</p> <p>Conditions it treats: _____</p> <p>Are you currently receiving treatments from another health care professional? YES NO If so, for what? _____</p>	<p>Surgery-date: _____</p> <p>Nature: _____</p> <p>Injury- date: _____ Nature: _____</p> <p>Do you have any other medical conditions (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) YES NO What? _____</p>	<p>Do you have any internal pins, wires, artificial joints or special equipment? YES NO What? _____ Where? _____</p>

What is the reason you are seeking Thai massage therapy? Please include where in your body you feel any issues or joint discomfort.

Informed Consent Form for Thai Massage Therapy

Please read the following and sign below and date if all information is clear and understood:

- In the event that client information needs to be shared, written consent will be first acquired from the client. Please note that all treatments, information and client files will remain confidential.
- The integrity of each client is respected. Thus the therapist will use a pain scale from 0-10 and should not exceed a pain of level 7. (0 is described as having no pain and 10 is described as the most excruciating pain possible). Communicate with the therapist to ensure that she knows your level of comfort during the entire session.
- Promptness is required for appointment times. In the event of lateness, the massage may be cut short. Fees will be maintained as per the schedule.
- **24 hour advance notice** is required when cancelling an appointment, except in cases of illness, emergency or increment weather. Cancellations without 24 hour notice will result in a charge (\$100.00) for your session, as that time has been set aside specifically for you.
- Payments must be made at the beginning of the treatment. Receipts will be issued.
- The client may refuse, modify, or terminate treatment at any time, regardless of prior consent given.
- The therapist may refuse to treat any client or part of the body with just and reasonable cause.

I _____, have read and understand the information contained in this form and consent to be treated for conditions discussed with the therapist today.

Date: _____

Client Signature: _____

Thai Massage Therapist Signature: _____